REPORT OF THE INFORMED CHOICE TASK FORCE OF THE BUREAU FOR SCIENCE AND TECHNOLOGY / OFFICE OF POPULATION

Office of Population
U.S. Agency for International Development
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REPORT OF THE INFORMED CHOICE TASK FORCE OF THE BUREAU FOR SCIENCE AND TECHNOLOGY/OFFICE OF POPULATION

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GLOSSARY

A.I.D.	United States Agency for International Development
CA	Cooperating Agency
IUD	Intrauterine device
LDC	Less developed country
NFP	Natural family planning
S&T	Bureau for Science and Technology
S&T/POP	Bureau for Science and Technology/Office of Population
VSC	Voluntary surgical contraception

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The Informed Choice Task Force appreciates the efforts of the Cooperating Agencies (CAs) of the Office of Population in responding frankly and thoughtfully to the questionnaire on informed choice distributed in November 1986 and in providing periodic updates during 1987.

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EXECUTIVE SUMMARY

This report summarizes the findings and conclusions of the Bureau for Science and Technology/Office of Population (S&T/POP) Informed Choice Task Force. The Task Force was formed in July 1986 to review the policies and procedures of the Cooperating Agencies (CAs) funded by the Office of Population in regard to the protection of informed choice in the provision of family planning services.

Based on policy statements of the Agency for International Development (A.I.D.), the Task Force has identified three conditions necessary for informed choice:

- Provision of information on a range of family planning methods;
- Provision of information on the advantages and disadvantages of available methods; and
- Efforts to ensure that a range of methods is actually available to the user, either through the service provider or through referral to another agency.

One of the major findings of the Task Force is that A.I.D. is at the forefront of the international population assistance community in respect to formulating policies and procedures on informed choice.

Based on replies of 29 CAs to a survey done in late 1986, the Task Force concluded that most of the CAs working in service delivery, information and training have made extensive efforts to incorporate principles of informed choice in their programs. Most CAs have developed or are in the process of developing policy statements, procedures and protocols regarding informed choice and have endeavored to enforce specific requirements among their less developed country (LDC) subgrantees and subcontractors. On the other hand, CAs have encountered some difficulties in verifying that their LDC subgrantees and subcontractors are actually using informed choice guidelines and protocols in their programs.

Major recommendations of the Task Force are:

- The creation of a CA Task Force to share information on procedures and materials related to informed choice;
- Development of a set of basic guidelines on all A.I.D.-provided family planning methods to assist service providers and client educators;

- Continued monitoring of implementation of informed choice policy by CAs, including a regular review of LDC subprojects;

- Support for studies on the implementation of informed choice, with emphasis on examining and identifying patterns that might indicate abuse of informed choice procedures and on the counseling and education process;

- Promotion of A.I.D.'s informed choice policy and procedures among international and national family planning organizations; and

- Additional support for the A.I.D. Informed Choice Task Force to enable it to refine guidelines for policy implementation, work closely with specific CAs, and consider issues affecting future programmatic and budgetary decisions.

In summary, the Informed Choice Task Force concludes that informed choice needs to be given a higher profile in LDC family planning programs, that initiatives already under way are contributing to this objective, and that CAs can make further improvements in their procedures to promote informed choice, particularly in the area of LDC project monitoring and evaluation. Further, the Task Force recommendations should promote more extensive implementation of A.I.D.'s informed choice policy.

I. INTRODUCTION

This report reflects the work of the S&T/POP Informed Choice Task Force, which was formed in July 1986 to review the policies and procedures of Office of Population (S&T/POP) CAs regarding informed choice in the provision of family planning methods. The purpose of the review was to identify particular strengths of the CAs in protecting informed choice and to note areas that require additional effort. The Task Force, which is chaired by Marilynn A. Schmidt, consists of the following S&T/POP staff members: Carol Dabbs, Carl Hemmer, Roy Jacobstein, and Sidney Schuler. Charles Johnson of the Asia and Near East Bureau is also a member. Alan Getson, formerly of S&T/POP, was a member until April 1987, when he took a new assignment in the Project Development Office of the Africa Bureau.

Task Force members analyzed A.I.D.'s position on informed choice, reviewed articles and books on informed consent and informed choice, held discussions with A.I.D. officials and representatives of other donor agencies, and conducted a survey of all A.I.D. centrally funded CAs regarding their implementation of informed choice principles.

This report represents the main conclusions and recommendations of the Task Force. It is intended to highlight some of the practical issues and problems that arise in the full-scale implementation of informed choice in developing countries. The Task Force considers this report to be a working document that summarizes the present policies and activities of S&T/POP and its CAs to protect informed choice in the provision of family planning services.

II. THE CONCEPT OF INFORMED CHOICE

This section reviews the Task Force's definition of informed choice and discusses the distinction between informed consent and informed choice.

II.1 Definition of Informed Choice

The definition of informed choice that has guided the work of the Task Force is derived from the description of this principle in the 1982 A.I.D. Policy Paper on Population Assistance (see Appendix A). According to this definition:

> Informed choice entails providing information to individuals on a broad range of family planning alternatives, informing them of the advantages and disadvantages of these alternatives, and taking steps to provide a wide choice of methods--directly or through referral.

Thus, informed choice has three requirements:

- Provision of information on a range of family planning methods;
- Provision of information on the advantages and disadvantages of available methods; and
- Efforts to ensure that a range of methods is actually available to the user, either through the service provider or through referral to another agency.

This latter requirement is based on the premise that informed choice is enhanced when a full range of methods is available.

Another point that is often overlooked in discussions of informed choice is that, to be truly "informed," the client must understand the risks of not using a family planning method; i.e., the relative health risks of childbearing compared with use of family planning methods.

II.2 The Concept of Informed Consent

Informed consent is a uniquely Western concept of relatively recent vintage. According to medical ethics experts Ruth R. Faden and Tom L. Beauchamp,[1] the term "informed consent"

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[1]Ruth R. Faden and Tom L. Beauchamp. A History and Theory of Informed Consent. New York: Oxford University Press, 1986.

was first used in a legal case in the United States in 1957 and became the watchword for an extensive public debate on the doctor-patient relationship and decision-making authority in regard to medical treatment. During the 1960s and 1970s, public opinion in the United States shifted from the view of the physician as the sole arbiter of the patient's treatment to the view that the patient has a right to complete and current information regarding his/her diagnosis, treatment and prognosis, and has the right to make his/her own determination regarding treatment, including the right to refuse treatment. The concept of the patient's right to self-decision was embodied in the policy statements of various medical groups as well as in legal cases. A landmark 1972 case, Canterbury v. Spence, ruled that "True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each."

Faden and Beauchamp have stipulated several conditions that are necessary for informed consent: the individual must act autonomously, which entails acting intentionally (willed in accordance with a plan), with understanding (fully adequate comprehension of the nature of the action and the foreseeable consequences and possible outcomes), and without controlling influences (coercion, manipulation and persuasion). Faden and Beauchamp define coercion as a deliberate attempt to influence another person by presenting a severe, credible and irresistible threat. The extent to which manipulation and persuasion influence the patient governs the judgment whether the principles of informed consent have been violated.

In actual practice, the ideal of informed consent is often compromised in some way: opinions regarding which facts are relevant may differ; patients may feel intimidated by medical providers or confused by medical terminology; or patients may prefer to abdicate decision-making responsibility to the service provider or a family member. Nevertheless, the moral onus is on service providers to ensure that every effort is made to optimize the conditions conducive to informed consent. In the United States, the legal requirements for informed consent are met by obtaining the patient's signature on a form authorizing specific medical treatment, typically for surgical procedures.

In developing countries, the concept of informed consent for medical treatment has received very little attention among health professionals and the general public for a variety of reasons. In many of these countries, in fact, informed consent is an alien concept. Patients, who often have very little knowledge of human physiology or experience with medical providers, rely completely on the judgment of medical professionals as to the best course of treatment. Also, patients are generally of a lower socioeconomic class than medical

professionals, which contributes to their unquestioning acceptance of the prescribed treatment. Furthermore, in most developing countries, the emphasis has been on expanding availability and access to health care. Patient education programs have focused on preventive measures such as sanitation and use of oral rehydration therapy--measures which do not require the patient to give his or her written consent to medical procedures. For medical care other than family planning, therefore, the practice of requiring the patient to sign a form authorizing surgery or some other medical treatment is virtually unknown in most developing countries. Nonetheless, in family planning programs the requirement that the patient provide his or her signature or mark on a consent form originated in voluntary surgical contraception (VSC) programs and is also followed in contraceptive research programs.

I.3 The Distinction Between Informed Consent and Informed Choice

Informed consent and informed choice convey slightly different meanings and yet are often used interchangeably. Since the issues of informed choice and informed consent are related, the Task Force distinguished between the terms as follows:

- o Context

  -- Informed consent is a Western concept closely associated with the judicial process, especially in litigation related to medical malpractice and negligence, while

  -- Informed choice seems to be a term coined by the international family planning community and especially A.I.D. to include all activities that help to ensure a voluntary choice of family planning method.

- o Method of Expression

  -- Informed consent has a more specific connotation; i.e., it is a written agreement to a medical procedure, while

  -- Informed choice is less defined, implying a decision-making process that generally precedes consent.

- o Parameters

  -- Informed consent conveys the sense of knowing to what one is agreeing, and therefore of choosing the agreed-upon action from several alternatives. Thus it

is possible to develop a precise operational term of informed consent, while

-- Informed choice is a more elusive term. What constitutes adequate information and appropriate levels of understanding is highly subjective and varies from culture to culture.

The Task Force focused on those issues that are more accurately characterized as informed choice issues.

At present, family planning service providers have much more experience with informed consent than with informed choice. Nevertheless, providers have learned a great deal about informed consent that can be applied to the implementation of informed choice. For example, the basic tenets of informed consent are the same for informed choice, namely, the provision of full information on the range of alternatives and their advantages and disadvantages, and the absence of coercion. Informed choice also requires the service provider either to make a full range of family planning methods available to the user or to refer the user to other sources for these methods.

III. AGENCY POLICY REGARDING INFORMED CHOICE

The policy of the United States Agency for International Development regarding informed choice is clearly enunciated in its 1982 A.I.D. Policy Paper on Population Assistance, which states:

> A.I.D. support for family planning service programs is based on two fundamental principles: voluntarism and informed choice. A.I.D. does not support programs in which there is any element of coercion of individuals to practice family planning or to accept any particular method of contraception. In fact, A.I.D. supported programs must include a description of the effectiveness and risks of all major methods of family planning and an agreement either to provide other family planning methods if requested or to refer couples to programs offering other methods as appropriate.

The Policy Paper states that one of the major objectives of A.I.D.'s population assistance program is "to enhance the freedom of individuals in LDCs to choose voluntarily the number and spacing of their children."

Particular attention has been paid to the issue of voluntary surgical contraception, since it is considered irreversible. A.I.D.'s Policy Paper requires fully informed consent in the provisicn of voluntary surgical contraception services:

> An explanation must be made to the client in his or her own language of the nature of the procedure, its risks and benefits, and its irreversibility. The client's witnessed signature or mark is required on the consent document, which must be retained for three years. . . Other family planning methods must be readily available to ensure that the client has a free choice of approved methods.

The Policy Paper also provides a definition of informed consent: "An individual's consent is considered voluntary if it is based upon the exercise of free choice and is not obtained by any special inducements or any element of force, fraud, deceit, duress or other forms of coercion or misrepresentation."

Voluntarism has been the basis of A.I.D.'s population program since its inception in 1961. A.I.D.'s policy on informed

choice has its origins in the 1967 Foreign Assistance Act, which authorized the U.S. government to support "voluntary family planning programs to provide individual couples with the knowledge and medical facilities to plan their family size in accordance with their own moral convictions and the latest medical information." Similar language was repeated in Congressional reports issued in 1968, 1973, 1974, 1978 and 1979.

A.I.D.'s policy of informing clients about a range of methods and requiring agencies to refer clients for services they themselves do not provide was reaffirmed in the FY 1986 Continuing Resolution passed by Congress (see Appendix B), which included language introduced by Senator DeConcini stating that:

> ...funds shall be available only to voluntary family planning projects which offer, either directly or through referral to or information about access to, a broad range of family planning methods and services...

The FY 1987 foreign assistance appropriations bill specifically required all recipients of A.I.D. funding for natural family planning (NFP) to comply with its policies regarding informed choice.

The theme of voluntarism and choice was emphasized in President Reagan's message to the International Conference on Population, held in Mexico City in August 1984:

> We believe population programs can and must be truly voluntary, cognizant of the rights and responsibilities of individuals and families, and respectful of religious and cultural values.

The President's statement was underscored by Ambassador James Buckley, head of the official U.S. delegation to the conference, who called for "ready access to the knowledge and services that will enable couples to exercise their right to determine when they will conceive a child."

IV. INTERNATIONAL POLICIES REGARDING INFORMED CHOICE

The consensus of governments around the world regarding informed choice is included in the final recommendations adopted by the 1984 International Conference on Population:

> The World Population Plan of Action recognizes, as one of its principles, the basic human right of all couples and individuals to decide freely and responsibly the number and spacing of their children. . . While this right is widely accepted, many couples and individuals are unable to exercise it effectively, either because they lack access to information, education and/or services or because, although some services are available, yet an appropriate range of methods and follow-up services are not . . . Family planning information, education and means should include all medically approved and appropriate methods of family planning, including natural family planning, to ensure a voluntary and free choice in accordance with changing individual and cultural values . . .

The recommendations called for all governments "as a matter of urgency" to make family planning information and services universally available.

Donor governments providing population and family planning assistance to LDCs generally have not developed detailed policies and procedures in regard to informed choice, largely due to their practice of allowing LDC governments to set their own policies and program guidelines in respect to family planning service delivery. International donor agencies such as the United Nations Fund for Population Activities and the World Bank have promoted principles of voluntarism, access to and free choice of a wide range of family planning methods, and adequate and appropriate client education, but have generally assigned responsibility for detailed implementation and monitoring to the LDC recipient organizations.

V. IMPLEMENTATION OF INFORMED CHOICE BY COOPERATING AGENCIES

V.1 Overview of CA Survey

Periodically, S&T/POP reviews the procedures and practices of its CAs regarding the promotion of informed choice. In May 1986, the Office commenced a comprehensive and systematic review of the implementation of the policy as carried out by the CAs funded centrally through A.I.D./Washington. These CAs represent about half (52 percent) of A.I.D.'s expenditures in population and family planning. Bilateral programs account for 41 percent; Regional Bureaus, 5 percent; and special A.I.D. initiatives, 2 percent. The initial assessment of the CAs included a review of their written policies, training materials, programmatic practices and monitoring procedures. Based on this preliminary review, the Informed Choice Task Force decided that a more specific, detailed questionnaire would yield more and better data for analysis.

In November 1986, a questionnaire on procedures and practices regarding informed choice (see Appendix C) was developed and sent to all 40 projects funded by S&T/POP. (The 40 projects are considered separate CAs; they represent 32 organizations, including nonprofit agencies, for-profit companies, universities, and other branches of the Federal Government.) A summary of the results of this survey is reported in the following sections.

Of the 29 CAs replying to A.I.D.'s questionnaire, six agencies indicated that although their work contributes to informed choice, the application of principles of informed choice is not directly relevant to their work. These CAs are involved in demographic data collection and analysis, technical assistance, the provision of training fellowships, and research in reproductive physiology. The 11 CAs that did not reply to the questionnaire are engaged in operations research, policy analysis and technical support services. Because none of the nonresponding CAs is directly involved in family planning service delivery, information and training, the Task Force did not consider further follow-up productive.

V.2 Major Findings of the CA Survey

Of the 23 CAs that replied to the questionnaire and affirmed that informed choice was relevant to their work, most indicated that they had made extensive efforts to incorporate principles of informed choice in their programs. Those actively involved in large-scale service delivery, information and

training programs in LDCs were more likely than other CAs to have developed detailed procedures and protocols.

V.2.1 Provision of Adequate Information on Multiple Methods

Most CAs involved in service delivery, information and training reported that they had taken the following measures to encourage service providers to make available to clients adequate information about multiple methods of family planning:

- Provisions requiring the availability of services and information on a broad range of methods had been incorporated into subagreements and subcontracts with LDC agencies;
- Written guidelines and policies on multiple methods had been developed and distributed to LDC subgrantees and subcontractors;
- Training programs for LDC service providers and in-service training courses for CA staff included a discussion of the importance of providing services and information on a range of methods;
- Referral systems for family planning methods not provided on-site had been developed;
- Information, education and communication materials suitable for both literate and illiterate populations and available in national language(s) were being developed and distributed; and
- Protocols for client education in both clinic- and non-clinic-based services had been instituted.

Most CAs reported that they had not supported mass media campaigns on multiple methods; this finding reflects the small number of CAs involved in mass media outreach.

One CA reported that it routinely checks quarterly reports from LDC grantees in regard to method mix, complication rates and practical training standards, and ensures that project design includes adequate supervision of providers and follow-up of clients.

V.2.2 Medical Guidelines for Service Delivery

Most CAs stated that they promote the use of appropriate medical guidelines for service delivery through measures such as training for LDC service providers and

development of protocols and procedures in clinic- and non-clinic-based services to screen for contraindications. Virtually all CAs involved in service delivery provide their LDC grantees and contractors with written guidelines on the delivery of specific methods; adherence to these guidelines is monitored by required program reports and site visits.

V.2.3 Promotion of Client Understanding of Method Use

CAs have taken a number of steps to promote client understanding of correct use of the method chosen, including protocols for LDC service providers, both in clinics and in nonclinic services; training for LDC service providers; and in-service CA staff training. One CA has undertaken client follow-up studies in six countries to assess the quality of client education and counseling and the quality of counselor training. Another CA noted that it conducts "patient satisfaction" studies for some projects in order to obtain feedback from users on the quality of family planning services.

V.2.4 Monitoring of LDC Providers

CAs have made various efforts to determine whether LDC providers are adhering to informed choice procedures and using the guidelines and protocols provided by the CAs. Such efforts include site visits, regular program reports from subgrantees and subcontractors, and program evaluations. According to the CAs, monitoring LDC subgrantees and subcontractors has been and continues to be the most difficult and costly part of implementing A.I.D.'s informed choice policy in a comprehensive manner.

V.3 Factors Affecting Implementation and Verification

Most CAs reported that they have no difficulty in undertaking measures under their own immediate control, including developing policy statements, procedures, protocols for LDC providers, training curricula, and requirements for inclusion in subagreements and subcontracts. All CAs involved in service delivery require their LDC subgrantees and subcontractors to ensure that adoption of family planning is voluntary and that information and services on a range of family planning methods are provided, either on-site or through referral. These principles are built into all new subprojects and are an essential condition of continued funding.

Most CAs involved in service delivery had made a concerted effort to distribute guidelines and procedures regarding client education and counseling to their LDC

subgrantees and subcontractors. These documents had been reviewed during regular site visits and training sessions. Nevertheless, some CAs reported difficulties in ensuring that their guidelines and procedures were being implemented throughout the clinic or service systems run by their LDC subgrantees and subcontractors.

V.3.1 Human Resources and Other Constraints

Several CAs pointed out that comprehensive monitoring of their subgrantees and subcontractors would require more extensive field visits and more elaborate reporting mechanisms than exist at present. Adoption of more elaborate monitoring measures would require additional staff, travel funds, and other resources.

CAs drew attention to particular difficulties in monitoring the information that clients receive. With regard to monitoring the quality of counseling, one CA commented:

> Monitoring the quality of counseling is difficult on a site visit, especially if all information-giving and counseling is done individually rather than in a group session. Enforcing improvement in quality is also difficult. . . . The existence of a written protocol for screening clients for contraindications, or the inclusion of this in a training course, is no guarantee that it is uniformly done by clinic or community-based distribution personnel. . . . Supervision, especially in rural areas, is expensive.

Another said:

> On-site monitoring to determine that individual clients each receive the information, education and guidance necessary to make an informed choice [can be difficult]. For example, service may be completely provided in a different language [i.e., an indigenous language] and therefore difficult to evaluate.

In most LDC family planning programs, the LDC subgrantee or subcontractor has taken major responsibility for monitoring counseling and service delivery through its clinic or outreach system. While much can be done within existing budgets to improve supervisory systems and upgrade various aspects of

service delivery and education programs, major programmatic changes would require sizeable funding increases.

V.3.2 Amount of Control/Leverage over LDC Providers

Since many CAs specialize in a particular sphere of activity and award comparatively small subgrants and subcontracts to LDC agencies, they do not always have the leverage over their LDC subgrantees or subcontractors to insist that they expend additional funds from other sources for counseling, materials development, training and commodities. This problem is especially acute if the subgrantee or subcontractor is a government agency and the grant or contract represents a miniscule portion of its total budget. One CA underscored this point, stating that it "has no leverage on government policies, financial support for supervision, and commodities availability."

V.3.3 Training

In regard to training, most CAs involved in training reported that the preparation of training materials, references and checklists incorporating informed choice is relatively easy, compared with ensuring that second-generation training courses include the same material. Training of LDC provider staff was considered by most CAs to be the most challenging part of implementing the informed choice policy. One agency emphasized the need for adequate training in counseling skills for local providers and commented:

> . . . in some regions appropriate trainers for such a component have not been identified, and a culturally appropriate curriculum has not been developed. Doctors, nurses, and auxiliary personnel all provide a different type of counseling, and need a different orientation. Medical school training does not encourage the necessary respect and listening skills on the part of doctors.

Among the techniques used in clinical training to emphasize the importance of informed choice and the role of the service provider in protecting informed choice were discussion of needs assessment data, a review of method mix in the clinic, interviews with clients, and pre/post-tests covering the trainees' knowledge of family planning methods.

V.3.4 Educational Materials for Promoting Client Understanding

Promoting client understanding of correct method use was frequently cited as a particular concern among the CAs involved in service provision, information and training. Most CAs cited the lack of educational materials as the most serious impediment to improving client education. One CA remarked, "The lack of adequate information, education and communication materials . . . is a common and urgent complaint of grantees worldwide." Several CAs specifically called attention to the lack of materials for illiterates, which makes client education more difficult. One CA commented:

> Nonliterate clients pose an especially difficult group to inform and serve, due to the scarcity of materials designed to inform nonliterates.

Another commented:

> In many regions, appropriate information and education materials are unavailable, especially for illiterate and semiliterate clients. In some cases, reference materials for community-based distributors with low educational levels are also lacking.

One CA suggested that a mechanism be established in each country to review locally available materials and recommend the best to other providers.

In regard to the more general issue of creating community awareness of family planning and the availability of specific methods, most CAs indicated that more extensive mass media campaigns would be helpful. As one CA noted, however, the LDC agencies involved in service delivery generally have "neither the expertise nor the interest" to develop mass media campaigns or communication materials. Linking LDC service providers with communication professionals and/or helping them to acquire the necessary skills to mount mass media campaigns and cultivate local media contacts has proved to be highly effective in many countries. Continued efforts are needed to extend media coverage of family planning, especially in countries with relatively new family planning programs.

V.3.5 Natural Family Planning

CAs working with LDC agencies providing NFP noted that these agencies were reluctant to become involved in counseling

clients on a range of contraceptive methods and to refer them to other agencies for services other than NFP. One CA explained:

> The majority of NFP-only programs are philosophically opposed to referring clients to providers of other methods. In addition, the information they give their clients about other methods is generally negative. Because this is based on the moral perspective of the NFP programs rather than on lack of knowledge, it is very difficult to change.

CAs cited two other reasons for the reluctance of NFP agencies based in LDCs to counsel clients on all family planning methods: first, this comprehensive counseling is very time-consuming; and second, many of the providers are nonmedical volunteers who are not well trained in other methods.

These difficulties notwithstanding, it should be noted that CAs working in NFP report that they require LDC subgrantees and subcontractors to provide information on a range of family planning methods and to refer clients desiring methods other than NFP to other sources.

V.3.6 Cultural Factors

The development of rigid guidelines on informed choice was seen as undesirable by one CA, which argued that the range of cultural values and service modalities existing from country to country calls for local decision-making regarding appropriate client education. "Client understanding . . . is an elusive concept and hard to measure," the CA stated.

One CA expressed concern about the cultural appropriateness of making clients sign consent forms:

> The concepts of "informed choice" and "informed consent" are foreign to many societies . . . . In many societies, especially those with repressive government systems, clients are reluctant to sign an "informed consent" document, not because they do not want to participate in a study or use a contraceptive method, but because they are fearful of the consequences of signing any paper.

Illiterates may be especially fearful of signing or putting their mark on an official-looking form that they cannot read.

V.3.7 Conflicts between Informed Choice and Medical Judgment

One CA raised a dilemma faced by family planning programs in developed and developing countries alike: "When clients request a method that is contraindicated, despite having been informed about the risks and side effects, informed choice becomes a problem." Thus, the client's desire for a specific method may conflict with sound medical practice and pose an ethical problem for the provider.

VI. CONCLUSIONS REGARDING INFORMED CHOICE IN A.I.D. CENTRALLY FUNDED PROGRAMS

One of the major findings of the Task Force is that A.I.D. is at the forefront of the international population assistance community in respect to formulating detailed and comprehensive policies and procedures on informed choice, as well as in respect to carrying out formal reviews of their implementation. Other international donor agencies, both governmental and intergovernmental, have strongly endorsed the principle of informed choice but have relied on LDC governments to interpret and implement it in accordance with local practices and conditions.

The Task Force devoted considerable attention to the question of the extent of A.I.D.'s responsibilities in ensuring informed choice in LDC family planning programs. In other words, to what extent can and should A.I.D.--and by extension its CAs--insist that LDC agencies receiving any amount of A.I.D. funds be required to undertake specific actions and to demonstrate that each and every family planning client understands the correct use of his/her method of choice and can accurately recall information about other methods? The Task Force concluded that ultimate responsibility for providing adequate information to clients rests with the local LDC agency. Nevertheless, the Task Force concluded that A.I.D. has a key role in promoting wider implementation of informed choice principles throughout the LDCs and in providing constructive suggestions to LDC agencies to aid them in improving service delivery and client education programs.

The Task Force believes that policymakers need to be cognizant of the cultural, social, political and economic differences between the United States and LDCs that result in different modes of health care service delivery and differing priorities in patient care. Factors such as staff shortages, heavy demand for services, socioeconomic differences between providers and clients, lack of educational materials for providers and clients, and widespread illiteracy make enforcement of a detailed educational regimen for each family planning method difficult. On the other hand, because access to alternative sources of family planning information and services is often limited or nonexistent in many LDCs, family planning providers have an added responsibility to furnish complete and accurate information.

In determining how well A.I.D.'s informed choice policy is being implemented, the Task Force had to confront the problem that requirements and/or guidelines specifying the actions that CAs must take to be in conformance with some aspects of the policy have not been developed, either by A.I.D. or by any other

agency. Those aspects of the policy that the Task Force considers to be well defined and widely implemented are:

- o The principle of voluntarism in adoption of family planning, which is included in the contractual requirements for CAs and their LDC grantees and contractors and is carefully monitored by A.I.D. and the CAs;

- o Informed consent for voluntary surgical contraception, which is ensured through adherence to detailed guidelines and by regular monitoring by A.I.D. and the CAs; and

- o Provision of a wide choice of methods, either on-site or by referral, which is a practice generally followed by CAs and LDC service providers.

From the Task Force's perspective, the main unresolved issue is what constitutes adequate information on the range of available family planning methods or on the specific method chosen by the client.

Beyond the A.I.D. Policy Paper on Population Assistance and Congressional legislation, no detailed explanation is available as to how donor agencies and LDC service providers should act to ensure that clients have adequate and complete information on family planning methods. Given the complexity of the issue and the many differences among LDCs and among LDC service provider agencies, however, the Task Force concluded that it does not seem feasible or even appropriate to develop specific requirements applicable to all CAs.

A.I.D.'s CAs have reported to the Task Force that they have taken various steps to implement and operationalize A.I.D.'s policy of informed choice within their individual scopes of work. Most CAs have developed or are in the process of developing policy statements, procedures and protocols regarding informed choice, and have endeavored to enforce specific requirements among their LDC grantees and contractors. CAs report difficulties, however, in verifying that their LDC subgrantees and subcontractors are actually using informed choice guidelines and protocols in service delivery and training programs. An even more difficult task has been to ensure full-scale implementation of the principles of informed choice throughout all levels of the LDC provider's system, especially among government health service networks.

The Task Force considers informed choice an important part of service delivery programs. While the CAs have already taken a number of initiatives and are planning additional efforts, the Task Force believes that informed choice merits

increased attention from CAs, and that more can and should be done to institutionalize informed choice concepts and practices in LDC programs. For example, training courses for CA staff as well as for LDC service providers need to emphasize consistently the importance of ensuring informed choice, and all materials provided to LDC subgrantees and subcontractors should underscore its importance and state minimal requirements to demonstrate compliance.

Several CAs expressed concern regarding the costs of the extensive monitoring needed to ensure compliance throughout service delivery systems, especially among large national programs and in rural areas. The Task Force recognizes that additional funds would be needed to make a concerted increase in program effort allocated to LDC provider staff training, on-site monitoring and follow-up, and production of materials, especially for nonliterates. Nevertheless, the Task Force believes that CAs can give increased emphasis to informed choice within existing budgets and can make some improvements in existing practices with respect to project monitoring and evaluation. For example, specific items on informed choice can be added to checklists for project monitoring visits, information required in regular project reports, and project evaluation guidelines.

In summary, the Task Force concludes that informed choice needs to be given a higher profile in LDC family planning programs, that initiatives already under way are contributing to this objective, and that CAs can make further improvements in their procedures to promote informed choice, particularly in the area of LDC project monitoring and evaluation.

VII. RECOMMENDATIONS REGARDING INFORMED CHOICE IN A.I.D. PROGRAMS

The Task Force recommends that S&T/POP take the following measures to promote more extensive implementation of A.I.D.'s informed choice policy:

1. Convene a special task force composed of representatives of CAs to share information on their experiences in implementing informed choice policies and procedures and to compile a small collection of exemplary materials, including guidelines for service delivery, training protocols, information, education and communication materials, questions for LDC project monitoring visits, report forms, and evaluations. Copies of the resource materials identified by the special CA task force should be distributed to all CAs and A.I.D. Missions.

2. Develop a set of basic guidelines for all A.I.D.-provided family planning methods to guide service providers and client educators (or adapt existing guidelines) and disseminate them widely to CAs, government and private agencies working in family planning in LDCs, and A.I.D. Missions. The guidelines should be brief, medically accurate, and appropriate to conditions in the LDCs.

3. Establish among CAs the implementation of a routine review of informed choice in their subprojects.

4. Disseminate among other family planning organizations, both international and national, information on A.I.D.'s informed choice policy and encourage them to adopt similar policies and procedures.

5. Conduct studies on the implementation of informed choice principles. Some studies should focus on examining and identifying patterns that might indicate abuse of informed choice procedures. Other studies should examine the counseling and education aspects of the implementation process.

6. Continue to provide information to A.I.D. Missions and Population Officers on the program implications of A.I.D.'s informed choice policy.

7. Continue to monitor and document, through various measures such as external evaluations and periodic reports, the progress of CAs in implementing A.I.D.'s informed choice policy.

8. Provide additional financial resources to the A.I.D. Informed Choice Task Force so that it can continue its work in refining guidelines for implementation of informed choice policy, work more closely with specific CAs to improve their procedures related to informed choice, and consider issues which require further attention, such as the relative roles and responsibilities of donor agencies and LDC service providers and the costs associated with field verification of informed choice. Funds are needed to hire outside consultants and support travel costs.

Appendix A

A.I.D. Policy Paper

Population Assistance

Bureau for Program and Policy Coordination
U.S. Agency for International Development
Washington, D.C. 20523

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Executive Summary

Assistance for voluntary population and family planning programs is an essential part of a cost-effective program of U.S. development assistance. Continued high rates of population growth significantly increase the cost and difficulty of achieving basic development objectives by imposing burdens on economies presently unable to provide sufficient goods and services for the growing population. Family planning assistance materially advances social and economic development; enhances individual freedom to choose voluntarily the number and spacing of children; and, provides critically important health benefits for mothers and young children.

Although only one of many challenges confronting less developed countries (LDCs), rapid population growth compounds the already serious and costly problems faced by LDC public and private sectors. Population and family planning policies and programs alone will not achieve economic miracles; they must be undertaken in conjunction with other economic and social measures to promote comprehensive development.

The need for voluntary family planning has never been greater. In the next twenty years, the world's population is projected to grow by almost 2 billion, and 90 percent of that growth is expected to occur in developing countries. There are already hundreds of millions of couples in the Third World, most of whom do not currently have access to modern family planning methods, who want smaller, healthier families. Twenty-five years ago only a handful of developing countries explicitly recognized the problems posed by rapid population growth; today over 60 LDCs, containing over three-fourths of the total developing world population, have adopted policies which address population growth.

A.I.D's experience in countries such as Thailand, Colombia, South Korea, and Indonesia demonstrates that a balanced program which provides modern contraceptive services and information, combined with strong community and family support for family planning, is the most effective way of helping couples achieve their fertility goals.

The underlying principles of U.S. assistance for family planning are voluntarism and informed choice. The implementation of A.I.D. assistance for population activities is governed by legislative requirements as well as A.I.D. policies. Specific legislation prohibits the use of U.S. government funds for abortion-related activities and requires all sterilization programs supported by A.I.D. to be shown to be truly voluntary. U.S. development assistance is not conditioned on the host government adopting a particular population policy; nevertheless A.I.D. actively seeks and responds to opportunities for policy discussions on voluntary family planning. A.I.D. intends to capitalize on the flexibility and innovativeness of the private sector as an important channel for the development and delivery of safe, effective contraceptives. A.I.D. also stresses the involvement of local institutions, and supports efforts to strengthen them.

The major focus of the U.S. program is voluntary family planning service delivery. The U.S. also supports dissemination of family planning information and education, including natural family planning; training for service providers; research on new contraceptive methods and improved delivery systems; and demographic and social science research and analysis designed both to improve voluntary family planning programs and to assist LDCs develop and improve their development policies and programs. U.S. population assistance supports the work of private voluntary and profit-making organizations and universities; multilateral and international population agencies; and LDC governments through bilateral agreements.

I. Background

A. Population Growth in Developing Countries

The 1982 world population is 4.6 billion and is growing at an increment of about 78 million annually. Ninety percent of this growth is occurring in less developed countries. Indeed, between 1980 and 2000, the number of women of child bearing age will grow by more than 60 percent or 480 million. The developing world's population of about 3.4 billion is growing at 2.1 percent annually; at this rate, it will double in 33 years. By contrast, the population of the developed countries will double in 116 years at the present rate of increase.

The world's rapid population growth is a recent phenomenon. Only several decades ago, the population of developing countries was relatively stable, the result of a balance between high fertility and high mortality. Life was a high risk proposition. Often, only one in two children survived infancy and early childhood. Epidemics, debilitating diseases exacerbated by chronic malnutrition, and extremely poor public health conditions all made early death an ever-present threat. Against these risks, fertility had to be high in order to assure that families survived. High fertility, far from being a problem, was a necessity.

More recently, developing countries have experienced extraordinary changes in their societies and economies, and the changes have been, for the most part, destabilizing ones—both demographically and socially. Death rates have dropped dramatically as nutrition has improved and the major causes of population-wide epidemics have been brought under control. Birth rates have also risen in some areas, as the traditional customs and taboos which tended to space and limit births have been dropped by the younger generation whose values and prospects differ from those of their parents. Populations began to expand rapidly as the traditional short and rather risky life expectancy gave way to one where the chance of staying alive had never been better.

B. Implications for Economic Development

Sustained economic development and the achievement of a decent life for LDC citizens can only occur when population growth no longer outpaces economic progress. The factors that can inhibit progress toward self-sustaining economic growth as well as frustrate individual and national aspirations include the following problems associated with high birth rates and rapid population growth:

- high dependency ratios;
- excessive exploitation of existing resources;
- low levels of household savings and investment which in turn can slow the development of markets for domestically produced and imported consumer goods;
- low labor productivity as the labor force expands more rapidly than the demand for new workers;
- inability to maintain, much less improve, basic services and human capital investments (health, education, technical training) which not only can diminish the future productivity of the country but can also result in both social and political instability;
- inability to take advantage of new technologies because the infrastructure and the financial and human capital necessary to make effective use of technological advances are lacking.

To speak of the impact of population growth in global terms alone, however, is to fail to appreciate the real impact on individuals, families and nations. The demographic transition (high to low rates of population growth) is characterized by unevenness, both between and within countries. The process of modernization, hastened in some countries by sound government policies, a vigorous private sector, and effective development assistance, has brought with it dramatic changes in many aspects of public and private life, among them a desire for smaller families and declining birth rates. In other less developed countries, or even in remote areas of countries which have enjoyed substantial economic progress, high fertility and lack of adequate resources may place severe strains on individuals, families and communities. In such circumstances population growth can inhibit improvements in living conditions and economic progress; at the same time, the options open to individuals to plan the number and spacing of their children may be circumscribed by lack of family planning information, education or services or by social and economic conditions which militate against understanding and effective use of modern family planning methods. Finally, especially in poor areas, the health and nutrition status of women and children is linked to their ability to regulate their fertility safely and effectively. Maternal mortality rises with the number of births and in-

fant mortality with births too closely spaced. Complications of pregnancy are more frequent among women who are very young or at the end of their reproductive years. While medical problems are associated with frequent and numerous pregnancies in all countries, in societies with wide-spread malnutrition and inadequate health conditions these problems are exacerbated. In turn, under such conditions, numerous and closely spaced births lead to even greater malnutrition of mothers and infants.

C. Family Planning in the LDC Setting

Developing countries vary considerably, not only in their socioeconomic settings and the type of infrastructures through which basic services, including organized family planning services, may be delivered, but also in their official policies on population. However, the vast majority of LDC governments support or accept family planning services, both as a means of lowering population growth rates and stabilizing the absolute size of the population, and as a means of improving maternal and child health through birth-spacing. Presently, over three-fourths of the people in the developing world live in countries with policies supporting the provision of voluntary family planning services.

The concept of spacing or limiting births is not new, nor is it Western. Traditionally, for instance in Africa, birth spacing has been ensured by long periods of abstinence or separation following a birth, and extended breastfeeding. Abortion and infanticide (or neglect of children leading to death) have been and continue to be means by which family size is limited in many places where modern family planning methods are unavailable. Modern family planning services provide a safe, effective and humane substitute for traditional methods which are no longer practicable or are less effective, safe or humane.

Demand for and effective utilization of family planning services tend to accompany progress in other development sectors. Among the factors that have been most responsible for the dramatic and rather rapid changes in attitudes about family size have been improvements in health, education, and employment opportunities (especially for women), and the ubiquitous phenomenon of urbanization. Additionally, modern family planning services, where accompanied by information and education about the concept and methods of birth spacing, contribute to increased demand for services.

D. Factors Influencing Fertility

Demographers agree that four direct biological factors determine fertility patterns: breastfeeding and lactation patterns, age at which sexual activity is initiated, contraceptive utilization and induced abortion. These determinants control the initiation of sexual activity, conception following intercourse, or births resulting from conception. A wide range of social, economic and cultural factors in turn influence fertility through one of these four "direct" determinants. Perhaps the most significant of these socio-economic or "indirect" determinants are health, female education, employment/income and urbanization. The interaction between the direct and indirect determinants of fertility is complex; however, on-going research and the evidence from field programs are beginning to offer some rather specific programmatic suggestions.

(1) Health

One of the reasons for high fertility levels in LDCs is high infant and child mortality. Traditionally, as discussed above, couples in LDCs wanted and needed large families. Where 20-30 percent of infants died before their first birthday, parents chose to have a certain number of "insurance births" to assure that a critical number of children would survive to adulthood. As general health conditions improve and infant mortality declines, the need for insurance births is greatly reduced and interest in family planning increases.[1] The relationship works the other way as well; family planning helps to lengthen the time between births, which in turn promotes the health and survival of both mother and infant.

(2) Education

Education of females appears to have a profound effect on fertility, especially when girls are able to complete the primary grades. Where initial improvements in female enrollment result in less than primary school completion, fertility tends to rise with rising educational attainment. Although the pattern varies greatly from country to country and region to region, and exceptions can be cited, it appears generally to be the case that where additional schooling takes girls beyond primary school, fertility tends to fall as

[1] The initial result of lower infant mortality may be a higher number of living children per woman since more infants survive. Fertility declines follow this initial rise.

education rises. As women become better educated, enter the wage economy, and have some measure of control over their earnings, their role in the family and the community changes. Education broadens women's horizons and predisposes them to accept new ways and ideas. Preference for smaller families, use of family planning, and later marriage all appear to be more acceptable to women who have been educated beyond the primary level, and all are correlated with lower fertility.

On the other hand, the prospects for education and training of women and girls can often be thwarted by their own fertility. Delay of childbearing either through postponement of marriage or the birth of the first child can allow girls the chance to complete higher education or training. And, with a smaller family size there is less need for girls to stay out of school to care for younger siblings.

(3) Income/Employment

Employment of women, especially outside the home, increases the opportunity costs of raising children, makes a smaller family a more attractive option, and heightens interest in the use of family planning to achieve the desired family size. The role of income *per se* in bringing birth rates down is less well understood. As aggregate income rises initially so does fertility, but with further increases in income the trend reverses, and fertility begins to drop. The threshold at which the trend reverses varies from country to country, and unfortunately has not been well defined.

(4) Urbanization

Urbanization brings with it more education, higher net costs of children, lower infant mortality, greater access to modern sector employment for women, and easier access to contraceptives. The result is a consistently lower incidence of births among urban women, who have roughly 25 percent fewer children on average than do women in rural areas. Probably the most significant difference between urban and rural women is their use of contraceptives. Contraceptive use is a function both of the desire to space births or limit family size and the availability of and access to appropriate modern methods of family planning. In urban settings those factors affecting demand for, as well as supply of, modern contraceptives are likely to encourage voluntary family planning.

E. The Role of Modern Contraception

Of the four "direct" determinants mentioned above, contraceptive use has the greatest potential impact on fertility; indeed, in the absence of modern family planning services, some socioeconomic changes (e.g., improved child health and changing patterns of breastfeeding) may actually lead to higher birth rates. In short, modern contraceptives provide the means by which individual couples can achieve their desired family size most effectively, safely, and humanely.

Existing demand for modern family planning services is not currently being met by programs in the developing world. World Fertility Survey data from 29 countries indicate that 48 percent of married women 15-49 years of age want no more children. A study of 18 of those countries suggests that the average birth rate of 32.3 per 1000 would drop to 23.5 births per 1000 population if all unwanted births were prevented. To summarize, existing demand for family planning services is great and is likely to become greater as development brings about improvements in socioeconomic conditions throughout the developing world.

II. The U.S. Population Assistance Program

A. A.I.D. Policy Objectives

Family planning programs are an essential element of the U.S. development assistance strategy, and this Administration has reaffirmed a 20-year U.S. commitment to voluntary family planning efforts. The objective of the A.I.D. population assistance program is twofold: (1) to enhance the freedom of individuals in LDCs to choose voluntarily the number and spacing of their children; and (2) to encourage population growth consistent with the growth of economic resources and productivity.[1] The two parts of this objective are reciprocal. The ability to determine freely the number and spacing of one's children allows the individual greater potential to take advantage of opportunities for improving skills, seeking employment and increasing income. Experience has shown that when couples can freely determine the number and spacing of their children, they tend to have smaller families and population growth rates tend to decline. Further, when aggregate national wealth and

[1] Rural to urban migration and the problem of refugees are population related issues, but they are being addressed in separate policy papers.

population are in balance, individual families tend to have better prospects for education, employment and health. Such increased opportunities and improvements in the standard of living tend to raise individual and family aspirations, and couples tend to prefer to have fewer children whom they can educate and care for well, rather than many to whom they cannot offer these advantages.

The basic premises of U.S. population assistance are the following:

- individuals and couples should be able to decide freely the size of their families;
- voluntary family planning programs are needed and wanted by the citizens of the Third World;
- it is in line with U.S. strategic as well as humanitarian interests to help LDC governments achieve economic development, and to support their citizens' efforts to attain a better life for themselves and their children;
- sustained economic development and the achievement of a decent life for all LDC citizens can only occur when population growth no longer outpaces economic progress;
- the impact of development resources is maximized through coordination of policies and programs that broaden access to education and employment, especially for women, with the provision of modern family planning services; and
- the U.S. has unique strengths in this area of international development assistance.

A.I.D. support for family planning service programs is based on two fundamental principles: voluntarism and informed choice. A.I.D. does not support programs in which there is any element of coercion of individuals to practice family planning or to accept any particular method of contraception. In fact, A.I.D. supported programs must include a description of the effectiveness and risks of all major methods of family planning and an agreement either to provide other family planning methods if requested or to refer couples to programs offering other methods as appropriate. A.I.D. supports the provision of family planning methods within the medical and cultural context of each particular country.

B. Population Program Assistance Activities

The Agency for International Development has traditionally played a strong role in supporting population programs, consistently leading bilateral and multilateral donors in program initiatives and in funding. A.I.D's cumulative population assistance since the mid-1960's exceeds $2 billion, and constitutes about half of all population assistance provided to the developing world. On an annual basis, it is estimated that donor assistance and host country government (excluding China) expenditures for population programs total something over one billion dollars. For the past several years, A.I.D's population account has represented about 20 percent of these aggregate budgets.

A.I.D's allocation of population funds reflects Agency priorities in the population sector. Voluntary family planning service delivery and related supplies form the heart of the program and consistently absorb the greatest proportion of population assistance. Support for service delivery systems includes: commodities, training for physicians, paramedicals and fieldworkers and technical assistance in the design and improvement of services. Innovative field oriented research to improve existing delivery systems and to develop new "outreach" programs for delivering family planning and health services that are less expensive and more appealing are also important A.I.D. supported activities.

A.I.D. has led the way among donors in developing and disseminating the most widely used high quality contraceptive methods in the world today; the U.S. will continue to support the development of promising new contraceptive methods and improvement of existing methods, as well as research on the safety and effectiveness of contraceptives under actual conditions in developing countries.

Accompanying the provision of services is dissemination of information and education on family planning and population, both for individual users and also for government policy makers. Where requested by governments, the U.S. provides technical assistance to help analyze government policies which may affect the availability of, and the demand for, family planning services, as well as to analyze the impact of rapid population growth on other development sectors, such as food, health and energy.

The U.S. population assistance program does not operate in isolation from our other development

efforts, but takes into account the linkages between population, health, nutrition, education, employment and agricultural productivity. A.I.D. has led the way in developing and applying new ways to measure program impact and the degree to which fertility and the use of family planning services is influenced by women's education and employment opportunities, child health and other social and economic conditions. Based on our knowledge of the relationship between population and other development factors, we seek to make our total development strategy for each country one in which the objectives and activities in all areas, including population are mutually reinforcing.

Successful family planning programs tend to occur in countries where there is a strong commitment by the host government, an infrastructure with the capacity to deliver services throughout the country, and social and cultural acceptance of the concept of family planning. The largest share of U.S. population assistance is directed to countries where these three conditions exist. In countries, notably but not exclusively in Africa where awareness of the impact of rapid population growth on sustained economic development and of the need and demand for modern family planning services is more recent, A.I.D. works closely with host governments and private organizations to help them analyze and strengthen their policies and programs. Where infrastructures are weak or inadequate, A.I.D. supports activities to strengthen local service delivery institutions and also works with the private sector.

In recent years, A.I.D. has increased the proportion of population funds allocated to bilateral family planning programs, reflecting not only the Agency's commitment to integrate family planning programs into overall country development assistance programs, but also the growing interest of LDC governments to collaborate with the U.S. in developing strong national family planning programs.

Among A.I.D.'s major strengths in assisting LDC population program efforts are its strong field presence and its early and sustained leadership in developing innovative approaches to low-cost service delivery that are responsive to particular country requirements. A.I.D. has also been a leader because of its strong analytical orientation, whether in the testing of outreach systems for delivery of family planning services, in analysis and interpretation of survey findings to measure program impacts, in biomedical research or in developing overall family planning strategies. The very size of the U.S. supported family planning effort is also one of its strengths; the U.S. provides about half of the Development Assistance Committee (DAC) assistance for population and is the principal donor to the United Nations Fund for Population Activities (UNFPA) and the private intermediaries. This preeminence gives the U.S. a unique voice in encouraging high quality voluntary family planning services for interested couples throughout the world. AID's population program in the 1980s is rooted in this highly successful past.

C. Specific Policies Governing U.S. Population Assistance

Beyond the fundamental principles of voluntarism and informed choice upon which U.S. population assistance is based, specific legislative requirements and A.I.D. policies govern assistance under this account.

(1) Abortion

In accordance with authorizing legislation adopted in 1974, A.I.D. must not provide support for abortion services or a number of other abortion-related activites, such as the provision of abortion equipment, or the motivation of persons to practice abortion. In January, 1981, A.I.D. discontinued funding of research on methods of abortion as a means of family planning. Funding of all such research was terminated in 1981, although A.I.D. continues to gather descriptive epidemiological data to assess the incidence, extent or adverse consequences of abortion.

All A.I.D. funded population contracts and grant agreements with private and voluntary organizations (PVOs) and with host governments incorporate language to prohibit use of A.I.D. funds for abortion-related activities; PVO subgrant agreements also incorporate such prohibitions.

Such prohibitions include:

- Procurement or distribution of equipment intended to be used for the purpose of inducing abortion as a method of family planning.
- Procurement or distribution of Menstrual Regulation (MR) kits.

- Special fees or incentives to women to coerce or motivate them to have abortions.
- Payments to persons to perform abortions or MR procedures or to solicit persons to undergo abortions or MR procedures as a means of family planning.
- Information, education, lobbying, training or communication programs that seek to promote abortion as a method of family planning.
- Funding of biomedical research which relates to methods of abortion as a method of family planning.
- Training of individuals for the performance of abortion as a means of family planning.

(2) Voluntary Sterilization

Section 104(f) of the Foreign Assistance Act enacted in 1978 prohibits the use of U.S. funds for *involuntary* sterilization. It states:

> None of the funds made available to carry out this part may be used to pay for the performance of involuntary sterilizations as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilization.

A.I.D. Policy[1] governing the use of Agency funds for sterilization provides that A.I.D. funds can only be used to support voluntary sterilization activities if the following six conditions are met:

1) *Fully Informed Consent.* An explanation must be made to the client in his or her own language of the nature of the procedure, its risks and benefits, and its irreversibility. The client's witnessed signature or mark is required on the consent document, which must be retained for three years.
2) *Availability of Other Methods.* Other family planning methods must be readily available to insure that the client has a free choice of approved methods.
3) *Incentive Payments.* No A.I.D. funds can be used to induce clients to accept voluntary sterilization; also the cost of the procedure must be such that it does not favor voluntary sterilization over other methods.
4) *Quality of Services.* The medical personnel must be well trained and the surgical equipment should be the best available that is suitable to the field situations in which it will be used.
5) *Integration with Health.* To the fullest possible extent, voluntary sterilization programs shall be conducted as an integral part of the total health care services of the recipient country and shall be performed with respect to the overall health and well-being of the prospective acceptors.
6) *Country Policies.* A.I.D. funded sterilization programs should be carried out in full cooperation with host country officials, and particular care must be exercised to avoid undue emphasis on any ethnic, political or religious minority.

Regulations setting out requirements for informed consent are included as part of all grants, contracts and subordinate agreements between A.I.D. and implementing organizations. Adherence to these guidelines and regulations is constantly monitored by A.I.D. to insure full compliance.

(3) Natural Family Planning

In 1981, Section 104(b) of the Foreign Assistance Act was amended to ensure that information and services relating to natural family planning (NFP) methods be included among the population activities supported by A.I.D. A.I.D. missions have been informed of this legislative amendment and of A.I.D.'s intention to see that natural family planning methods, defined to include all those methods which rely on periodic abstinence, are integrated into all relevant forms of population assistance, including research, training, service delivery and information programs, wherever this is appropriate to the culture and desires of the recipient population and its government.

Although natural family planning itself is not a new concept, it has received increased attention and interest in the last decade. A.I.D. missions should continue to explore ways of encouraging the inclusion of natural family planning approaches within the programs of public and private family planning agencies working in the country. A.I.D. policy governing the funding of natural family planning activities is based on the same principles of voluntarism and informed choice which govern activities related to other methods of family planning. A.I.D. gives preference in its funding to programs which provide a wide range of choices in family planning methods (excluding abortion) and strongly encourages such programs to include information

[1] Policy Determination (PD) 3 *(formerly PD-70)* summarized below is attached as an Annex.

and/or services related to methods of natural family planning. All A.I.D. supported population programs must demonstrate that they are free of coercion regarding not only the practice of family planning, but also the choice of a particular family planning method.

(4) The Relationship Between Population and General Development

Recognition of the reciprocal links between fertility and other aspects of development led Congress to amend the Foreign Assistance Act to include Section 104(d). This section states that:

> (1) Assistance under this chapter shall be administered so as to give particular attention to the interrelationship between (a) population growth, and (b) development and overall improvement in living standards in developing countries, and to the impact of all programs, projects, and activities on population growth.

Implementation of 104(d) requires A.I.D. to maximize the impact of scarce development resources, not only by avoiding support to development programs that appear to work at cross-purposes, but also by building upon what is known about the links between social and economic progress and fertility decline. A.I.D. has interpreted 104(d) as a mandate to work for improvements in the socioeconomic setting within which voluntary family planning services are provided, (an important development goal in its own right) in order to support parents' growing interest in smaller families as well as their ability to utilize modern, effective contraceptives to achieve their desired family size. In implementing this mandate, A.I.D. does not seek to tie assistance to fertility reductions, but rather to coordinate development activities and the availability of family planning services so that they are mutually reinforcing.

(5) Contraceptives

It is A.I.D.'s general practice to provide to other countries only those contraceptives approved by the Food and Drug Administration for use in the U.S.

III. Factors Affecting Policy Implementation

Constraints to the achievement of population assistance policy objectives include:

- weak or inconsistent government policies;
- regulations which inhibit efficient distribution of contraceptives;
- inadequate infrastructures for service delivery; and
- social and economic conditions, e.g., poor health, low educational levels, and low income levels, especially for women, which militate against the acceptance or effective use of modern family planning methods.

There are a variety of government policies and socioeconomic changes which often tend to encourage (or at least not discourage) high fertility; for example, the breakdown of traditional practices which have served to ensure child spacing; protective labor legislation making it more difficult for women to work; the lack of regulations prohibiting child labor; the settlement of nomadic people; and the trend away from prolonged breastfeeding (one of the most important traditional means of postponing the next pregnancy) to intermittent breastfeeding and early weaning. There are also a variety of socioeconomic changes which are associated with higher fertility in their early stages, although over the long term they are associated with smaller families (increased female education, improved health and increased family income, for example).

Most LDCs, often with U.S. or other donor assistance, are currently investing heavily in development activities in a number of sectors; most LDCs also have stated policies to reduce population growth. However, often there is little attention to integrating or coordinating these development programs and policies so as to maximize their combined impact. For instance, in some countries, family planning services are virtually unavailable outside the major cities; at the same time, governments are investing in family income generation and education programs in rural areas—programs that are likely to foster couples' interest in limiting family size and thereby increase the demand for modern family planning services. In many areas, family planning services have not been integrated with existing maternal/child health programs, although the former is a critical factor in improving health status in most LDCs.

Where the constraints to acceptance or effective use of modern contraception are rooted in the lack of improvement in basic living conditions and economic opportunities, A.I.D. is careful to coordinate its development activities in other sectors with its support for family planning pro-

grams so that the two are mutually reinforcing. A.I.D. also works with LDC countries to help them analyze and strengthen their policies, which may in some cases include modification of regulations that inhibit contraceptive distribution, and in others focus on improved maternal and child health or education opportunities for females. Where infrastructures are weak or inadequate, A.I.D. supports institutional development activities or works with the private sector which often has more efficient channels for delivery of services than the government. The major priority emphases of the Agency—an expanded role for government-to-government discussions on country policies, the private sector, institutional development, and technology transfer—are particularly relevant to overcoming major constraints to successful implementation of U.S. and LDC population policy objectives.

A. Host Country Policies

A.I.D.'s experience has been that family planning programs are most successful where governments support strong service delivery systems, are committed to curbing excessive population growth through provision of voluntary family planning services, and where this commitment is translated into a clear population policy, backed by policies stressing improved education, health and employment opportunities, especially for women. In countries where continued high population growth rates appear to be eroding economic development, A.I.D. includes this factor in its policy discussions with the government. While the U.S. does not and will not make development assistance conditional on the host government adopting a particular population policy, A.I.D. will continue to seek and respond to opportunities for policy-level discussions on voluntary family planning. Indeed, many of the family planning program "successes" in Asia and Latin America involved not only substantial bilateral support for expansion of quality family planning services, but also a continuing official dialogue on the policy and institutional reforms needed to improve the quality and coverage of the programs. A.I.D.'s application of Section 104(d) of the FAA is an important element in ongoing discussions on population and development policies. In addition, A.I.D. will continue to sponsor the development and use of a variety of tools for analyzing and demonstrating the impact of rapid population growth on economic progress, making these programs available to interested LDC governments as they examine the full range of their development objectives, programs and problems.

B. Private Sector

In most countries, the distribution of contraceptives began through the private sector: private physicians prescribed contraceptives for their patients; some methods of family planning were available over the counter; and private voluntary organizations offered services, most often in urban areas. The private sector has acted as an important "supply side" force, responding to demands for services and also demonstrating to the government how efficient contraceptive distribution systems could be implemented. After governments begin to provide services, there remains a mix (which varies by country) of public and private sector delivery systems. In a number of countries, the government relies on the private sector to provide all or a large proportion of the services available.

Over the past several years, A.I.D. support to private voluntary organizations has amounted to roughly one-third of the population assistance program. This support is channeled for the most part through large U.S. based or international intermediaries that implement programs in LDCs through or in collaboration with local organizations.

Family planning service delivery, whether private or public, has typically involved clinic-based physician-oriented services. Although effective, such programs are costly and often biased toward urban consumers. In an effort to reach the rural population, and the poor in particular, modified programs have been developed to meet the needs and circumstances of isolated areas. Increasing the number of distribution points and types of contraceptive methods offered is critical to expanding the accessibility of services. In an attempt to increase services and stimulate greater private sector involvement in the delivery of family planning A.I.D. is placing greater emphasis on community based distribution involving paraprofessional and volunteer personnel. Additionally, in many developing countries, A.I.D. supports commercial retail sales (CRS) programs under which family planning is delivered through the commercial sector. A.I.D. will stress the need for family planning delivery systems to become less dependent on external resources, by systematically encouraging

greater local fundraising, voluntarism and community participation, fee-for-services, and improved management efficiencies in all programs. The Agency will also support efforts by U.S. private firms involved in the manufacture and distribution of contraceptives to promote similar development in LDCs. To the extent practicable, the methods, research, and experiences of such firms should be adapted and utilized in developing countries.

C. Institutional Development

Strengthening and fostering the direct involvement of local institutions in the development process will continue to be actively pursued under the A.I.D. population assistance program. Both public and private institutions are involved in the delivery of family planning services in LDCs. The magnitude of effort needed to make services available to all individuals who want them, and the inadequacy of infrastructures to deliver such services in the majority of countries, point to the importance of strengthening a variety of types of local institutions which are or could be effective service providers.

Appropriate institutions range from local women's groups, to private family planning associations, to Ministries of Health. In many countries it is important to have family planning services included as part of government maternal and child health (MCH) services, due to the real as well as perceived links between MCH and the spacing or limiting of births. Increased effort is also being directed to the involvement of local community organizations in the delivery of services as well as in the dissemination of information and education about both the concept of family planning and contraceptive methods. The mobilization of community resources (labor, materials, money, leadership) as a contribution to government-financed or private sector projects is an important means of encouraging community interest in a service, as well as fostering initiative and building local management capabilities.

The population assistance program seeks not only to involve local institutions in service delivery, but also to build or strengthen the capacity of local demographic and social science research institutions, government units responsibile for policy analysis and development, training institutions, and systems through which information, education, and communications about family planning reach potential clients.

The effectiveness of local organizations depends on such things as sound allocation and use of resources; quality of leadership; clarity of articulated goals and programs; and flexibility in implementation of programs. Improving organizational effectiveness may require changes in structure and function, in management systems, or in people's knowledge and skills. For this reason, greater attention must be given to building management and skills-training capacities into local organizations.

While it is generally understood that public policies affect the success of development efforts, less well understood are the ways in which government policies may handicap the effectiveness of local institutions. For instance, government policies may regulate the import and/or distribution of contraceptive supplies, fix prices at levels that militate against cost recovery, or define, in a limiting way, the role and functions of a private organization.

D. Technology Transfer

One of the strengths of the U.S. population assistance program has been the transfer of U.S. scientific and technological know-how to LDCs implementing family planning programs. The U.S. has led the way in developing, testing and disseminating the most widely used contraceptives and family planning delivery systems. A.I.D. is increasing the amount of its support for the development of promising new contraceptive methods and for research on the safety and effectiveness of contraceptives tested under actual LDC conditions. In addition to the transfer of technology directly applicable to the delivery of contraceptives, A.I.D. has sponsored the development and dissemination of a variety of technologies for analyzing and demonstrating the impact of rapid population growth on economic progress, making these tools available to LDC governments as they examine their policy and program goals. Demand from LDCs for technologies developed by the U.S. continues to be high. Our ability to transfer technology appropriate to various country needs has given the U.S. a longstanding leadership role in this field.

IV. Conclusion

Population Assistance will continue to be an essential element of U.S. development assistance. The content and direction of the U.S. program is guided by a number of factors:

- the commitment to helping LDCs achieve self-sustaining economic growth;

- the belief that individuals and couples should be able to decide freely the size of their families;

- the conviction that sustained economic development and the achievement of a decent life for all LDC citizens can only occur when population growth no longer outpaces economic progress;

- the evidence that voluntary family planning programs are needed and wanted by citizens of the developing world;

- the belief that it is in line with U.S. strategic as well as humanitarian interests to help LDC governments achieve national economic goals, and to support the efforts of their citizens for a better life for themselves and their children; and

- the growing evidence that the U.S. has unique strengths in this area of international development assistance.

Strengthening and fostering the direct involvement of local institutions in the development process will continue to be actively pursued under the A.I.D. population assistance program. A.I.D. will capitalize on the flexibility and innovativeness of the private sector in the search for new and better ways to make safe, effective and acceptable contraceptives widely available. There will be increased attention to the needs and interests of the consumer of the services, so that the services will meet, to the fullest extent possible, the cultural preferences of both current and potential users. Finally, A.I.D. will stress in its programming the integration of family planning services with health and other development activities.

V. Annex

PD-3 (September 1982) *(formerly PD-70 June 14, 1977)*

A.I.D. Policy Guidelines on Voluntary Sterilization

I. Overview

The *World Population Plan of Action* of the World Population Conference of 1974 observed that; "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so...."

The Foreign Assistance Act (FAA) of 1961 (as amended) reflects additional considerations:
(1) the process of economic and social development which is in turn affected by the pace, magnitude and direction of population growth; and,
(2) in many LDCs high rates of population growth limit attainment of broader development goals, contribute to economic hardship and hazardous health conditions, and deny opportunities for improved quality of life for many parents and their children.

In carrying out a comprehensive population assistance program *authorized by the FAA*, A.I.D. has responded to the growing number of LDC requests for assistance and has helped to make the various methods of family planning permitted by our legislation available on a broader scale to the rural and urban population for use on a strictly voluntary basis.

More recently, LDC governments and non-government organizations have requested assistance to extend the availability of voluntary sterilization (VS) services.* Such requests are partially in response to the preparatory work conducted by various organizations which have received A.I.D. support, including the Association for Voluntary Sterilization (AVS), the Pathfinder Fund, the International Fertility Research Program (IFRP), and the Johns Hopkins University Program for International Education in Gynecology and Obstetrics (PIEGO) as part of its broad program of advanced training in obstetrics and gynecology. These organizations have contributed to signifi-

*VS service programs include those activities which are primarily intended to provide voluntary male and female sterilizations to persons requesting this type of contraceptive procedure. For purposes of this discussion, however, VS training programs are included, since training generally requires that trainees conduct supervised procedures on patients who have voluntarily presented themselves at a service/training facility for sterilization.

cant advances in the development of new surgical techniques which make sterilization safer, simpler and less expensive as an outpatient procedure. They have developed specialized equipment and given LDC medical personnel specialized training in the practice of obstetrics and gynecology, including endocrinology, identification of cancerous conditions, maternal care, and the management of infertility and fertility, including sterilization procedures.

In providing support for sterilization services, A.I.D. must reaffirm its long-standing and complete commitment to the basic principle of voluntary acceptance of family planning methods and determine basic conditions and safeguards within which A.I.D. support for sterilization activities can be provided. These conditions and safeguards are needed because of the special nature of sterilization as a highly personal, permanent surgical procedure and to ensure that the needs and rights of individuals are scrupulously protected.

The official positions of national governments are mixed. While voluntary sterilization has become a basic part of comprehensive family planning services in many countries, in some there is only unofficial approval for action by non-government agencies while in other countries there is opposition to the method. A.I.D. staff and A.I.D.-funded grantees and contractors must be fully aware of national sensitivities and must receive AID/W and mission approval before making any commitments on commencing support for sterilization activities in any context.

II. General Guidelines

A.I.D. acknowledges that each host country is free to determine its own policies and practices concerning the provision of sterilization services. However, A.I.D. support for VS program activities can be provided only if they comply with these guidelines in every respect.

A. Informed Consent: A.I.D. assistance to VS service programs shall be contingent on satisfactory determination by the USAID (bilateral programs) and/or A.I.D.-funded grantees or contractors that surgical sterilization procedures, supported in whole or in part by A.I.D. funds, are performed only after the individual has voluntarily presented himself or herself at the treatment facility and given his or her informed consent to the sterilization procedure.

Informed consent means the voluntary, knowing assent from the individual after he or she has been advised of the surgical procedures to be followed, the attendant discomforts and possible risks, the benefits to be expected, the availability of alternative methods of family planning, the purpose of the operation and its irreversibility, and his or her option to withdraw consent anytime prior to the operation. An individual's consent is considered voluntary if it is based upon the exercise of free choice and is not obtained by any special inducements or any element of force, fraud, deceit, duress or other forms of coercion or misrepresentation.

Further, the recipient of A.I.D. funds used all or in part for performance of VS procedures must be required to document the patient's informed consent by (a) a written consent document in a language the patient understands and speaks, which explains the basic elements of informed consent, as set out above, and which is signed by the individual and by the attending physician or by the authorized assistant of the attending physician or (b) when a patient is unable to read adequately a written certification by the attending physician or by the authorized assistant of the attending physician that the basic elements of informed consent were orally presented to the patient, and that the patient thereafter consented to the performance of the operation. The receipt of the oral explanation shall be acknowledged by the patient's mark on the certification and by the signature or mark of a witness who shall be of the same sex and speak the same language as the patient.

Copies of these informed consent forms and certification documents for each VS procedure must be retained by the operating medical facility, or by the host government, for a period of three years after performance of the sterilization procedure.

USAID Missions should note their responsibility to monitor A.I.D.-assisted VS programs-whether such programs are funded bilaterally or by A.I.D.-funded grantees or contractors—to ensure continuing adherence to the principle of informed consent. In order to carry out this monitoring function effectively, all proposed programs—either bilaterally funded or funded by A.I.D.-supported intermediaries—shall be approved by the mission and AID/W prior to any commitment of funds or promise to commit funds for VS activities. In carrying out this responsibility, USAID staff should be thoroughly familiar with local circumstances and government administrative patterns and be able to communicate effectively with host country representatives.

B. Ready Access to Other Methods: Where VS services are made available, other means of family planning should also be readily available at a common location, thus enabling a choice on the part of the acceptor.

C. Incentive Payments: No A.I.D. funds can be used to pay potential acceptors of sterilization to induce their acceptance of VS. Further, the fee or patient cost structure applied to VS and other contraceptive services shall be established in such a way that no financial incentive is created for sterilization over another method.

D. Quality of VS Services: Medical personnel who operate on sterilization patients must be well-trained and qualified in accordance with local medical standards. Equipment provided will be the best available and suitable to the field situations in which it will be used.

E. Sterilization and Health Services: To the fullest possible extent, VS programs—whether bilaterally funded or conducted by A.I.D.-funded private organizations—shall be conducted as an integral part of the total health care services of the recipient country and shall be performed with respect to the overall health and well-being of prospective acceptors. In addition, opportunities for extending health care to participants in VS programs should be exploited to the fullest. Consideration must also be given to the impact that expanded VS services might have on existing general health services of the recipient country with regard to the employment of physicians and related medical personnel and the use of buildings or facilities.

F. Country Policies: In the absence of a stated affirmative policy or explicit acceptance of A.I.D. support for VS activities, USAIDs should take appropriate precautions through consultation with host country officials in order to minimize the prospect of misunderstandings concerning potential VS activities. In monitoring the consistency of A.I.D.-supported VS programs with local policy and practices, USAIDs and A.I.D.-funded donor agencies shall also take particular note of program activities among cultural, ethnic, religious or political minorities to ensure that the principles of informed consent discussed under "A" above are being observed and that undue emphasis is not given to such minority groups.

Addendum to PD-3 *(formerly Addendum to PD-70, 2/9/81)*
Additional A.I.D Program Guidance for Voluntary Sterilization (VS) Activities

1. INTRODUCTION: The previously provided Policy Determination No. 3 (PD-3), remains in effect. However, in light of several years experience, additional clarification of a number of points relating to the application of PD-3 and specific interpretation of its provisions appears to be needed.

2. APPLICABILITY OF PD-3: PD-3 states "A.I.D. support for VS program activities can be provided only if they comply with these guidelines in every respect". This means that the provisions of PD-3 must be applied if A.I.D. funds are used for whole or partial direct support of the performance of VS activities. However, as also noted in PD-3, "A.I.D. acknowledges that each host country is free to determine its own policies and practices concerning the provision of sterilization services". The provisions of PD-3 do not apply if A.I.D. provides support for population and family planning programs within a country and provision of VS services is not called for in the support agreement, i.e., VS activities may be a part of the host country's program, but A.I.D. funds are not used to support such services. For example, if A.I.D. support for VS program activities is geographically confined to particular parts of a country, PD-3 applies only to those areas with VS program activities supported by A.I.D. PD-3 does not apply if activities and projects are only peripherally related to provision of VS services, for example, A.I.D. support for construction of multipurpose buildings or broad-based training in reproductive health which includes VS techniques. Finally, in A.I.D.-supported population and family planning programs in host countries which use A.I.D. funds for activities other than VS and support VS activities with their own or other non-A.I.D. funds, PD-3 does not apply.

3. INFORMED CONSENT: The recipient of A.I.D support used fully or in part for performance of VS procedures must obtain and document voluntary informed consent as part of the conduct of any VS procedure. A.I.D. does not require any specific format for this procedure. However, the elements of the procedure described in PD-3 (i.e., an explanation of the nature of the procedure, the attendant risks and benefits, availability of alternative methods of

family planning, that the procedure is irreversible, and that the patient may withdraw consent) all must be part of the process of obtaining informed consent.

4. METHODS OF PAYMENT: All acceptor and/or provider payments in cash or kind beyond VS service costs as well as fees charged for VS and other contraceptive services shall be established in such a way that no financial incentive is created for sterilization over another contraceptive method.

(A) Payment of Acceptors: It should be noted that guidance differs for payments which may be made to acceptors of VS as contrasted to payment to providers of VS (guidance applicable to providers of VS services is described in para 4.B. below). As stated in PD-3, para C, "no A.I.D. funds can be used to pay potential acceptors of sterilization to induce their acceptance of VS". Further, A.I.D. support generally cannot be provided to VS services which include incentive payments paid to potential acceptors. For example, a VS program supported by A.I.D. cannot be supplemented with acceptor incentives to induce acceptance of sterilization services. Determination of what constitutes an incentive must be made locally based on thorough knowledge of social and economic circumstances of potential acceptors. In general, recompense to acceptors for legitimate, extra expenses related to VS program services such as transportation, food during confinement, medicines, surgically related garments and dressings and the value of lost work are not considered incentive payments and are eligible for A.I.D. support. It should be emphasized that these payments must be of a reasonable nature and aimed at making VS services equally available at the same cost as other contraceptive services. For example, payment for lost work must correspond to a reasonable estimate of the value of lost labor over a reasonable duration of convalescence.

(B) Payment of Providers of Services: In light of experience, it seems desirable to modify the previous A.I.D. program guidance relating to reimbursement for VS services as defined in AIDTO Circular 393 (10/27/77), page 6, section 3, "operating service costs", para. 4. The suggested prohibition of reimbursement to providers of VS services on a per-case basis has not proven practical in that payment per case or procedure is the time-honored method of paying for surgical procedures both in developed and less developed countries. Reimbursement of physicians, paramedical and other service personnel on a per-case basis can be an acceptable procedure. Compensation to providers for items such as anesthesia, personnel costs, pre and post-operative care, transportation, surgical and administrative supplies, etc., on a per-case basis is also generally acceptable. These payments to providers must be reasonable relative to other medical and contraceptive services provided so that no financial incentive is created for the providers to carry out VS procedures compared to provision of other methods of family planning. As in the case of payments to acceptors, this is a judgment which will have to be made on a country and program specific basis. However, in both cases, AID/Washington will provide assistance and guidance in making such determinations, and decisions relating to application of PD-3 should be submitted to AID/Washington for review. Even though payment on a per-case basis is often customary, A.I.D. Missions are advised to encourage patterns of service delivery and methods of payment which do not unduly emphasize VS procedures compared to other methods of fertility control. For example, if physicians who carry out the surgery are paid on a per-case basis and they have no role in the selection or counseling of patients, these service providers cannot induce additional patients to accept sterilizations over other contraceptive methods. Payments of physicians on a per-session rather than a per-case basis may also serve the same function. Since payments on a per-case basis do raise questions, often of a complex nature, beyond those raised by other types of compensation, where a mission can persuade a government to use such other frameworks for payment, whether immediately or phased-in, it should do so.

(C) Payment of Referral Agents: In some countries fieldworkers are employed to inform and refer potential acceptors of contraceptive methods including VS. When extra expenses are incurred in informing and referring VS acceptors, a per-case payment of these costs is acceptable. Again, as is the case with payments to providers and/or acceptors, a country or program specific determination that the payment is for legitimate extra expenses or activities associated with VS referral must be made. The aim is to make all available contraceptive methods available at the same cost to the acceptor.

APPENDIX B

DECONCINI AMENDMENT

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TITLE II—BILATERAL ECONOMIC ASSISTANCE

FUNDS APPROPRIATED TO THE PRESIDENT

For expenses necessary to enable the President to carry out the provisions of the Foreign Assistance Act of 1961, and for other purposes, to remain available until September 30, 1987, unless otherwise specified herein, as follows:

AGENCY FOR INTERNATIONAL DEVELOPMENT

Agriculture, rural development and nutrition, Development Assistance: For necessary expenses to carry out the provisions of section 103, $639,613,000: *Provided,* That up to $5,000,000 shall be provided for new development projects of private entities and cooperatives utilizing surplus dairy products: *Provided further,* That not less than $6,000,000 shall be provided for the Vitamin A Deficiency Program: *Provided further,* That, notwithstanding any other provision of law, up to $10,000,000 of the funds appropriated under this paragraph may be available for agricultural activities in Poland which are managed by the Polish Catholic Church or other nongovernmental organizations.

Population, Development Assistance: For necessary expenses to carry out the provisions of section 104(b), $234,625,000: *Provided,* That none of the funds made available in this Act nor any unobligated balances from prior appropriations may be made available to any organization or program which, as determined by the President of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization: *Provided further,* That none of the funds made available under this heading may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions; and that in order to reduce reliance on abortion in developing nations, funds shall be available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services: *Provided further,* That in awarding grants for natural family planning under section 104 of the Foreign Assistance Act no applicant shall be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning; and, additionally, all such applicants shall comply with the requirements of the previous proviso: *Provided further,* That nothing in this subsection shall be construed to alter any existing statutory prohibitions against abortion under section 104 of the Foreign Assistance Act.

Health, Development Assistance: For necessary expenses to carry out the provisions of section 104(c), $166,762,500.

Child Survival Fund: For necessary expenses to carry out the provisions of section 104(c)(2), $75,000,000, notwithstanding section 10 of Public Law 91-672 and section 15(a) of the State Department Basic Authorities Act of 1956.

Education and human resources development, Development Assistance: For necessary expenses to carry out the provisions of section 105, $155,000,000: *Provided,* That of this amount not less than

Source: Legislation on Foreign Relations Through 1986. Volume 1. Washington: U.S. Government Printing Office, 1987. p. 492.

APPENDIX C

LETTER AND QUESTIONNAIRE SENT TO
COOPERATING AGENCIES ON
INFORMED CHOICE

Dear:

Ensuring that couples enjoy informed choice in their access to family planning services is a concern we all share. The measures Cooperating Agencies take to provide a setting for the provision of services conducive to informed choice is the most important evidence of this concern.

The Office of Population appreciates the timely responses provided to our earlier inquiry regarding your policies and procedures that relate to informed choice. These responses clarified many of the complex issues involved. In order to complete our review, a short questionnaire has been developed, a copy of which is enclosed. While some Cooperating Agencies are not heavily involved in the provision of services we would like to give each the opportunity to make comments on this important issue. So, even if the enclosed questionnaire does not seem to apply directly to your A.I.D.-sponsored activities, we would appreciate your completing and returning it by December 1, 1986.

Please direct your responses and any questions to Marilynn Schmidt, ST/POP/IT, who can be reached at 703-235-9867.

Thank you again for your assistance.

Sincerely,

Duff G. Gillespie
Agency Director for Population

Attachments: a/s

Cooperating Agency _____ Date _____

1. Indicate those measures you take to encourage service providers to make adequate information about multiple methods available to clients.

_____ training for service providers

_____ subagreement requirements (provide copy)

_____ see that referral system for methods not provided on site is in place

_____ written CA guidelines/policies (provide copy)

_____ in-service CA staff training

_____ see that IEC materials are in national language(s)

_____ see that IEC materials are suitable for both literate and illiterate populations

_____ see that clinic protocols/procedures include client education

_____ see that protocols/procedures for non-clinic based services include client education

_____ media capaigns

_____ other (specify): _____

Comments:

Cooperating Agency _____ Date _____

2. Indicate those measures you take to promote the use of appropriate medical guidelines.

_____ training for service providers

_____ subagreement requirements (provide copy)

_____ written CA guidelines/policies (provide copy)

_____ in-service CA staff training

_____ see that clinic protocols/procedures include screening for contraindications

_____ see that protocols/procedures for non-clinic based services include screening for contraindications

_____ checklist of contraindications is available to subcontractors/subgrantees for their service providers

_____ provide technical assistance to subcontractors/subgrantees in formulating appropriate guidelines to screen clients

_____ other (specify): _____

Comments:

Cooperating Agency _____ Date _____

3. Indicate those measures you take to promote client understanding of the correct use of the method chosen

_____ training for service providers

_____ subagreement requirements (provide copy)

_____ written CA guidelines/polices (provide copy)

_____ in-service CA staff training

_____ see that clinic protocols/procedures include measures to verify that the client understands the correct use of the method

_____ see that protocols/procedures for non-clinic based services include measures to verify that the client understands the correct use of the method

_____ other (specify): _____

Comments:

Cooperating Agency _____ Date _____

4. Considering the measures to promote Informed Choice indicated in your responses to Questions 1-3, what actions do you take to determine whether providers in fact use these measures?

_____ site visits (attach protocol)

_____ regular programmatic reporting (specify)

_____ evaluations

_____ research studies (list)

_____ other (list)

11/86

Cooperating Agency _____ Date _____

5. In implementing a policy of informed choice,

   A. which measures are easiest to implement?

   B. which measures are most difficult?